

FOSTER CARE, ADOPTION, AND GUARDIANSHIP MEDICAID REVIEW

RETURN THIS FORM TO RECEIVE CONTINUOUS COVERAGE

INSTRUCTIONS FOR COMPLETION OF THE REVIEW FORM

This review form is sent to you to fulfill a requirement of the Medicaid program. It is important to complete the form and return it before the date on the form. The form must be signed by the adoptive parent, legal guardian, or by the child in supervised apartment living as the situation applies. An income maintenance worker in the Department of Human Services may contact you. In order to process your review, the income maintenance worker may request further verification or necessary information; including information about persons who will help to pay for the medical care.

Failure to return the form and cooperate in the review process can cause interruption of medical payments. Therefore, we ask your assistance in the review. If you have questions, please contact your service worker.

SPECIFIC INSTRUCTIONS

Foster/Adopted/Subsidized Guardianship Child and Siblings in Same Placement: List the child being reviewed and all of the child's siblings that are in the same placement. Do not list siblings living in other places. Only one review form is needed for the sibling group.

Student Status: Check if the child is a full-time or part-time student.

School and Grade: Enter the name of the school and the grade of the child and siblings in placement.

Name and Address of Employer: Enter the name and address of the employer of each child under review. If not employed, enter "N/A." Verification of the child's earned income is required for the whole calendar month.

Income: Enter all the unearned income that the children are eligible for or receiving. This means all unearned income that may be assigned to the Department and income from relatives, as well as income that the children receive from the sources listed. Write in the amount if known; otherwise check each item they are eligible for or receiving. (Unearned income is Social Security benefits or interest for example.)

Resources of Foster/Adopted/Subsidized Guardianship Child and Siblings Listed: Enter the type of resource and location of resources that the child owns. If there are no resources, enter "no."

Vehicles: Enter whether the child owns a vehicle and, if so, enter information about the vehicle.

Health Insurance for Child and Siblings Listed: Enter whether the child or siblings in the same placement have health insurance. Also enter the policy holder and company name. Where possible provide the policy number. Parents will receive a more extensive form to complete if the policy has changed.

Address of Parents: Enter the name and address of the natural mother and father for foster children and children in subsidized guardianship and the name and address of the adoptive child's adoptive parents. If the siblings of foster or subsidized guardianship children have different parents, identify the child with the parent.

IV-E Information: For foster care children in supervised apartment living, enter "yes" or "no" to the question about finishing school by age 19. **The whole section is to be completed for foster children in family homes and day care.**

Expected Changes: Report any changes that are expected to take place in the child's future, particularly within the next six months. This could include expected changes on any of the items listed on this form. Also include if the child is pregnant.

Signature and Date: The child in supervised apartment living, adoptive parent, or legal guardian for subsidized guardianships is expected to sign this form indicating that the information is true, correct, and complete.

Foster Care, Adoption, and Guardianship Medicaid Review

			Review Month	Due Date
Social Worker	County No.	IABC Case No.	Medical Review Worker	

Foster/Adopted/Subsidized Guardianship Child and Siblings in Same Placement

If more room is needed, attach a separate sheet.

	Child	Sibling 1	Sibling 2	Sibling 3
Child's Name				
State ID No.				
Is this child a student?	If yes: <input type="checkbox"/> Full time <input type="checkbox"/> Part time	If yes: <input type="checkbox"/> Full time <input type="checkbox"/> Part time	If yes: <input type="checkbox"/> Full time <input type="checkbox"/> Part time	If yes: <input type="checkbox"/> Full time <input type="checkbox"/> Part time
School Name and Child's Grade				

Income. Child's income only.

Is this child employed?	If yes: <input type="checkbox"/> Full time <input type="checkbox"/> Part time	If yes: <input type="checkbox"/> Full time <input type="checkbox"/> Part time	If yes: <input type="checkbox"/> Full time <input type="checkbox"/> Part time	If yes: <input type="checkbox"/> Full time <input type="checkbox"/> Part time
Name and Address of Employer (attach verification of				
Social Security Benefit	\$	\$	\$	\$
SSI	\$	\$	\$	\$
Child Support	\$	\$	\$	\$
Military Allotment	\$	\$	\$	\$
Relatives/Friends	\$	\$	\$	\$
Interest Income	\$	\$	\$	\$
Other Income	\$	\$	\$	\$

Resources of Foster/Adopted/Subsidized Guardianship Child and Siblings Listed

If more room is needed, attach a separate sheet.

	Amount	Location	Name or Names of Person Owning
Checking Account <input type="checkbox"/> Yes <input type="checkbox"/> No			
Savings <input type="checkbox"/> Yes <input type="checkbox"/> No			
Stocks or Bonds <input type="checkbox"/> Yes <input type="checkbox"/> No			
Trust Fund <input type="checkbox"/> Yes <input type="checkbox"/> No			
Escrow Account <input type="checkbox"/> Yes <input type="checkbox"/> No			
Other <input type="checkbox"/> Yes <input type="checkbox"/> No			

	Make/Year	Market Value	Amount Owed	In Whose Name?
Automobile <input type="checkbox"/> Yes <input type="checkbox"/> No				
Truck/Motorcycle <input type="checkbox"/> Yes <input type="checkbox"/> No				

Health Insurance for Child and Siblings Listed Yes No

List Persons Covered	Policy Holder	Policy No.	Insurance Company Name

List child/children's names:	Name – Child	Name – Sibling 1	Name – Sibling 2	Name – Sibling 3

Address of Parents

List child's mother's name and address:				
List child's father's name and address:				

IV-E Information (Complete this section for foster care cases only)

Does DHS have placement and care responsibility?	<input type="checkbox"/> Yes <input type="checkbox"/> No			
Child in a voluntary placement over 90 days?	<input type="checkbox"/> Yes <input type="checkbox"/> No			
Will child finish school by age 19?	<input type="checkbox"/> Yes <input type="checkbox"/> No			
Are parental rights terminated?	<input type="checkbox"/> Yes <input type="checkbox"/> No			
Date of last RE2 (attach court order)				
Are one or both parents of child incapacitated or deceased?	<input type="checkbox"/> Yes <input type="checkbox"/> No			
If both parents in household, is either parent of child employed?	<input type="checkbox"/> Yes <input type="checkbox"/> No			

Expected Changes (SW/JCO):		Continuing Eligibility Determination (IMW):	
Social Worker/JCO Signature	Date	IMW Signature	Date

Right of Appeal

If you are dissatisfied with any action or failure to act with regard to your application for Medicaid, you have the right to request an appeal. A hearing must be requested in writing. Send or take your appeal to the Department of Human Services (DHS) office in your county or you may submit it directly to the Department of Human Services, Appeals Section, 5th Floor, 1305 E Walnut Street, Des Moines, IA 50319-0114. You may also file an appeal electronically, at <https://dhssecure.dhs.state.ia.us/forms/>.

You may present your appeal at the hearing yourself or have someone else present it for you. If you wish, an attorney may represent you at the hearing. However, there are no provisions whereby the Department can pay the attorney fee. Contact your worker for information regarding legal services that may be available in your area.

When the request for a hearing regarding your Medicaid is made within 30 calendar days from the date of notification, a hearing shall be held. When the request for a hearing is made more than 30 calendar days but less than 90 calendar days after the notification, the Director of the Iowa Department of Human Services must approve whether a hearing will be held. Any discussion between you and the county office does not extend this time period.

**Policy Regarding Discrimination, Harassment,
Affirmative Action and Equal Employment Opportunity**

It is the policy of the Iowa Department of Human Services (DHS) to provide equal treatment in employment and provision of services to applicants, employees and clients without regard to race, color, national origin, sex, religion, age, disability, political belief or veteran status.

If you feel DHS has discriminated against or harassed you, you can send a letter of complaint to:
Iowa Department of Human Services, Administrator, Diversity Program Unit, 1305 E. Walnut, Des Moines IA 50319-0114; phone (800) 972-2017; fax (515) 281-4243.

Applicant's copy: Upon request your county Department of Human Services office shall provide a copy of this completed form to you.

CERTIFICATION STATEMENT

I understand that I assume full responsibility for the accuracy of the statements on this form. I understand the Department of Human Services will use this statement to redetermine eligibility for Medicaid.

I am aware that this child's case may be selected by the Department for a complete Quality Control or other review of eligibility for Medicaid. Should this case be selected for verification, I will cooperate fully in the verification.

I know that I must notify the county Medicaid eligibility staff of the changes in the child's income or property or living circumstances. I will report changes to the county office no later than 10 days from the date the change occurs.

I understand that the social security number of the child will be used in the administration of the Medicaid program to check the identity of the child, prevent duplicate participation, and make mass changes. The SSN will be used in computer matching with Iowa Workforce Development, Internal Revenue, and the Social Security Administration and in other program reviews and audits to make sure that the child is eligible for benefits from the Department of Human Services. The SSN will also be furnished to the Internal Revenue Service regarding the benefit eligibility for the child as well as to other states to see if the child is getting benefits from any other state. The information obtained from these computer matches may result in criminal or civil action or administrative claims against persons fraudulently receiving benefits.

I understand that support payments that are assessed and intended for medical expenditures are assigned and must be paid to the Department to the extent of the medical benefits received.

I understand that the Department may intervene to establish paternity and secure medical support on behalf of a child in foster care and secure medical support according, but not limited to, Iowa Code Chapters 232, 234, 252A, 252B, 252C, 252D, 598, and 600B.

I understand that the Department by law does not need my consent to recover Medicaid payments made on the child's behalf. The Department may intervene on the child's behalf to make claim against any person or party that may be responsible for the cost of medical expenses.

I further understand that the Department will provide documents or claim forms describing the services paid by Medicaid upon request or the request of an attorney acting on behalf of the child. These documents may also be provided to a third party when necessary to establish the extent of the Department's claim.

I understand that federal and state law and rules permit access by authorized federal and state officials to Medicaid provider's records. I also fully understand that my acceptance of Medicaid for the child is consent for these authorized persons to have access to the child's medical or other health care records during the time the child is Medicaid eligible. Should my child become enrolled in a managed health care plan, I consent to disclosure of medical information, including any clinical mental health information, by my child's medical providers to the HMO, PHP, other managed care providers, or to the authorized administrative body contracted by the managed care provider to determine appropriateness, quality, or utilization of services my child received while enrolled in managed health care.

I am aware that Section 1128B of the Social Security Act provides federal penalties for fraudulent acts and false reporting. I am aware that Iowa's laws provide that anyone who obtains or attempts to obtain or who aids or abets any person to obtain public assistance to which the person is not entitled is guilty of violating Iowa Code Chapter 294A.

I understand that I will need to provide the Department with proof, either documentation from the INS, or other documents the Department considers to be proof of the immigration status of the child in foster care or subsidized adoption who is not a United States citizen or national. I understand that alien status may be subject to verification with INS, which will require submission of certain information from this application form to INS.

I KNOW WHAT I HAVE REPORTED HERE. I BELIEVE IT IS TRUE, CORRECT AND COMPLETE.

I CERTIFY under penalty of perjury, by signing my name below that I am a U.S. citizen or national or that the information I have given about my immigration status is correct. Adult household members must sign the statement for dependent children.

Signature or Mark of Applicant or Payee (or legal guardian)	Date
Signature or Mark of Other Parent in the Home	Date